Anakinra (Kineret®) Prior Authorization Request Form

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE Mail Order Pharmacy (TMOP). Express Scripts is the TMOP contractor for DoD.

Your patient receives their prescription drug benefit from the Department of Defense (DoD). The DoD prescription drug benefit plan requires that we review certain requests for coverage with the prescribing physician. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage can be provided. **Before giving the prescription to the patient, please make a copy of this form, complete the following questions and give the completed form, along with the prescription, to the patient. Please instruct the patient to send this completed form, along with the prescription, to Express Scripts for processing.**

If Express-Scripts already has your patient's prescription and has requested that you complete this form, the completed form may be faxed to: (877) 895-1900 (toll-free) or (602) 586-3911 (commercial). A copy of this form and explanations of the underlying clinical rationale and criteria for approval are available at www.pec.ha.osd.mil/PA_Criteria_and_forms.htm.

Drug for which Prior Authorization is requested: Anakinra (Kineret®)

Step 1

Please complete patient and physician information (Please Print)

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Member # _____ Phone #: _____

Secure Fax #:

Step 2

Please complete the clinical assessment:

1. **Is this a continuation of therapy with anakinra?**
   If yes, benefit is approved for 1 year. Drug benefit coverage is limited to a quantity not to exceed 42 syringes (6 packages of 7 syringes) per 6 weeks.
   If no, proceed to Question 2.
   ☐ Yes ☐ No

2. **Is the patient at least 18 years of age?**
   If yes, proceed to Question 3.
   If no, benefit coverage not approved.
   ☐ Yes ☐ No

3. **Is anakinra being prescribed for the treatment of moderately to severely active rheumatoid arthritis?**
   If yes, proceed to Question 4.
   If no, benefit coverage is not approved.
   ☐ Yes ☐ No

4. **Will the patient be receiving adalimumab (Humira), etanercept (Enbrel®) or infliximab (Remicade®) in combination with anakinra?**
   If yes, benefit coverage is not approved.
   If no, proceed to Question 5.
   ☐ Yes ☐ No

5. **Has the patient had an inadequate response to at least one disease-modifying anti-rheumatic drug (DMARD)?**
   If yes, benefit is approved for 1 year. Drug benefit coverage is limited to a quantity not to exceed 42 syringes (6 packages of 7 syringes) per 6 weeks.
   If no, benefit coverage is not approved.
   ☐ Yes ☐ No

Step 3

Please sign and date

_____ _____

Prescriber Signature Date

Latest revision: April 2003